NASTAD REPORT

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Technical Assistance and Capacity Building Assistance for Minority Communities: A Report from the NASTAD STATUS Project

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The National Alliance of State and Territorial AIDS Directors (NASTAD) represents the nation's chief public health program managers who have programmatic responsibility for HIV / AIDS prevention, care, and treatment programs. The Supplemental Technical Assistance, Testing, and Unified Services (STATUS) Project is a key part of NASTAD's response to the Minority AIDS Initiative (formerly known as the Congressional Black Caucus Initiative) to better serve communities of color disproportionately impacted by HIV / AIDS. The STATUS Project focuses on three primary areas:

1. technical assistance and capacity building assistance (TA / CBA) provided by health departments to minority CBOs;
2. targeted testing efforts (including the use of rapid tests); and
3. referral efforts linking HIV counseling and testing with medical and other support services.

Through this research project, funded by CDC in August 1999, NASTAD had the opportunity to identify model health department programs and initiatives and to position health departments to lead future national initiatives in these areas. This report examines only the first area of focus – technical assistance and capacity building; a separate report will examine issues relating to targeted testing and referrals.

Phase I of the study was based upon a written assessment of AIDS directors along with a focused discussion group of AIDS directors and a comprehensive literature review. Phase II was based upon a more in-depth examination of model programs and best practices. The specific methods are outlined in Appendix A; highlights of the literature review are provided in Appendix B.

This report was authored by two NASTAD consultants, the Principal Investigator of the STATUS Project, Raymond A. Smith, Ph.D., and Liisa Randall, M.A. The literature review was conducted by NASTAD consultant Beth Meyerson, M.Div. Additional assistance was provided by current and former NASTAD staff members.

TA/CBA TO MCBOS: SUMMARY FINDINGS

State, territorial, and local HIV / AIDS program directors identified organizational development and management as the most important technical assistance needs of minority community-based organizations (MCBOs).

HIV / AIDS programs within state, territorial, and local health departments offer a wide array of training and technical assistance opportunities. Capacity and methods for providing needed training and technical assistance, however, varies significantly between jurisdictions.

State, territorial, and local health departments are uniquely positioned to identify and address the technical assistance needs of individual CBOs. They are also uniquely positioned to serve as "brokers" for technical assistance. Health departments require additional resources and technical support of staff to more fully address identified technical support needs of CBOs.

From the health department perspective, National / Regional Minority Organizations (NRMOs) may be best qualified to provide generalized assistance and support related to providing culturally competent interventions and organizational management.

ASSESSMENT FINDINGS

Current Health Department TA/CBA Activities

"Capacity building is like teaching someone how to fish. Once someone learns how to fish, they can catch the fish they need to feed multitudes…"
- AIDS director in focus group

In order to provide a comprehensive portrait of TA / CBA services potentially available to minority community based organizations (MCBOs), it was necessary to survey health departments about their overall ability to deliver TA / CBA in general. AIDS directors were asked to identify whether or not they were currently able to offer any of a list of prevention-related services derived from the logbook used by NASTAD's TA / CBA coordination program. (This logbook documents all of the areas in which TA / CBA is known to be offered throughout all NASTAD member jurisdictions, and is as close to an exhaustive list of types of health department TA / CBA as is available.)

Responses to the assessment indicate that health departments offer a wide variety of technical assistance opportunities to local HIV / AIDS service providers.

TABLE 1
Technical Assistance and Capacity Development Opportunities Offered by State Health Departments

Topic	Percent Offering
Planning	
Community planning	96%
Goals, objectives and priority setting	86%
Epidemiology	78%
Recruitment for community planning groups	78%
Needs assessment	77%
Behavioral and social science	75%
Community participation and engagement	71%
Youth involvement	55%
Statewide Coordinated Statement of Need	51%
Group process and facilitation	35%
Social marketing	35%
Linkages with school health programs	31%
Program Implementation/Evaluation	
Counseling and testing	90%
STD prevention and treatment	84%
Evaluation	82%
Partner notification / partner counseling and referral	78%
Interventions and intervention effectiveness	77%
Outreach to communities of color	73%
Quality assurance	67%
Referrals	65%
Substance abuse and HIV linkages	63%
Youth interventions	63%
Cultural competency	61%
Linkages between care and prevention	55%
Prevention case management	47%
Perinatal transmission	45%
Syringe / needle access or exchange	35%
Treatment adherence	31%
Medicaid	29%
Organizational Development and Operations	
Budget development	61%
Grant writing	65%
Infrastructure development and management	49%
Program administration and finance	53%
Program monitoring and management	59%
Staffing / personnel issues	39%

Survey respondents were asked to indicate topics currently addressed by technical assistance and/or capacity building assistance activities offered or supported by the health department. It should be noted that the question was broadly worded, and thus indicated only whether or not health departments currently offer such services; it did not attempt to identify how often, with what proficiency, or to what extent services were offered. These findings are available in Table 1.

Survey findings suggest that health departments currently have high capacity with respect to providing technical support in many areas related to program planning (e.g. conducting needs assessments, priority setting, use of behavioral and social science). This is likely due to implementation of the community planning initiative and the associated national investment in technical assistance and skills-development. Health department capacity to provide support to local service providers and community planning groups has clearly benefited from this investment.

Health departments also appear to possess relatively high capacity to provide technical assistance and support for program components which are traditionally considered "core" public health functions (e.g., HIV counseling and testing, STD treatment, partner counseling and referral). It is noteworthy that respondents indicated relatively low capacity with respect to providing technical assistance and support for treatment-related program components (e.g., prevention of perinatal transmission, treatment adherence and Medicaid), although this could very likely be due to the fact that this was administered through NASTAD's prevention programs.

Health departments currently possess relatively low capacity to provide technical assistance and support in areas that can be broadly categorized as "organizational development and program operations" (e.g. program administration, finance, personnel issues). No statistically significant differences in capacity according to annual AIDS incidence were noted in terms of current capacity to provide technical assistance and support in any topic area included on this survey.

Survey respondents were also asked to indicate topic areas in which the health department itself offered training and/or certification to local HIV/AIDS service providers. These findings are represented in Table 2. A majority of health departments provide training and/or certification in what could be considered "core" HIV/AIDS program areas such as HIV prevention counseling, partner counseling and referral and sexually transmitted diseases and confidentiality. A slim majority of respondents indicated that their health department currently offered training and/or certification on outreach strategies and linkages between substance abuse and HIV. Relatively few health departments appear to possess the internal capacity to offer training on more specialized topics.

TABLE 2

Training and Certification Offered to CBOs and Other Providers Directly by State Health Departments

Topic	Percent Offering
HIV prevention counseling	90%
Partner counseling and referral services	69%
Linkage between STDs and HIV	67%
Confidentiality	65%
Outreach strategies	59%
Linkage between substance abuse and HIV	53%
Prevention strategies targeting youth	45%
Interview methods and outreach skills	45%
Legal issues for providers	35%
Outreach to communities of color	33%
Prevention case management	31%
Strategies for effective referral	28%
Adherence to treatment regimens	24%
Application of social marketing to HIV prevention	22%
Developing health communication messages	22%
Other	24%

Perceived Technical Assistance Needs of Minority-Operated CBOs

I think that part of the problem around providing technical assistance is that an AIDS organization is there for AIDS and is ready and understands the needs and is buying into the technical assistance. I think when you're talking about a minority community-based organization that hasn't always dealt with AIDS, you've got a whole different set of challenges…" – AIDS director in focus group

Having identified the broad parameters of their current TA/CBA services in the items above, AIDS directors were asked to establish a relative ranking of six areas in which the TA/CBA needs of minority CBOs were unique. (The six items were drawn from the literature review and earlier focused discussion groups; Relative rankings are presented in Table 3.) The results clearly indicated that AIDS directors viewed the chief unique needs of MCBOs as being related to organizational concerns. Indeed, more than half (51%) scored a lack of sufficient infrastructure as the top issue, giving this item a mean rank of 1.98 out of 6.0. The second highest-scored item was MCBOs' lack of diverse sources of funding (mean ranking = 2.72). The third highest ranked item (mean ranking =3.45) was that many MCBOs are not AIDS-specific or are relatively new to AIDS issues. (These areas are explored further below in case studies of the TA/CBA programs in Rhode Island and New Jersey, both of which provide services in such areas as non-profit management, leadership development, and grantwriting trainings.)

It is not until the fourth and fifth ranked items that sociocultural issues emerge, such as having distinct cultural characteristics (mean ranking =3.72) or that they serve communities that may distrust health care systems (mean ranking=3.77). Survey respondents also resoundingly rejected the idea that MCBOs perceive health departments as lacking appropriate expertise (mean ranking=5.32).

TABLE 3
Ranking: Technical Assistance and Capacity Building Needs of Minority CBOs
n=49

The technical assistance and capacity building needs of minority CBOs are unique because....	% ranking #1	% ranking #2	Mean rank
...they sometimes lack sufficient infrastructure	51%	28%	1.98
...they often lack diverse sources of funding & other resources	19%	40%	2.72
...many are not AIDS-specific or relatively new to AIDS issues	13%	11%	3.45
...they often have distinct cultural characteristics	13%	6%	3.72
...they serve communities that may distrust health care systems	4%	11%	3.77
...they perceive health departments as lacking appropriate expertise	4%	6%	5.32

Respondents were also asked to indicate other technical assistance and capacity building needs of minority-operated CBOs. Responses underscored limited infrastructure as the most pressing TA / CBA issue facing minority-operated CBOs. Among the specific areas indicated by survey respondents:

- Grant writing
- Fiscal management
- Program design and evaluation
- Board development
- Recruitment and retention of staff
- Strategic planning
- Fund raising
- Coordination and collaboration
- Organizational leadership

Several respondents noted that minority-operated CBOs that are AIDS-specific are not "part of the mainstream CBO network" and that this hinders their ability to build infrastructure and diversify funding.

It should be noted that the foregoing findings are strictly based upon the perceptions of AIDS directors, not those of MCBOs, which were beyond the scope of research for this project. As one AIDS director noted in a follow-up focused discussion group in which

these findings were discussed, "We see the CBOs through our eyes, and we see organizational infrastructure as the problem…and I just don't know how different it would look if we did the same survey with the CBOs that we're talking about, whether the cultural competency piece might be higher on the schedule." NASTAD looks forward to continuing to develop its connections with community-based agencies in order to be able to examine this and other related questions with their direct input.

Providers of Technical Assistance and Support for Minority Operated CBOs

"[Sometimes] there's a lack of trust when we say, "I'm from the government; I'm here to help you, and I'm glad to be here…" - AIDS director in focus group

While the preceding data clearly indicates that health departments are well placed to provide many types of TA / CBA to MCBOs, it was recognized that there are other TA / CBA providers as well. Indeed, as a result of the community planning initiative and activities associated with CDC directly funding minority-operated CBOs to provide HIV / AIDS services, a substantial investment has been made in supporting a national technical assistance network.

Focus group participants were somewhat divided on the extent to which technical assistance and capacity building for CBOs is an appropriate role for health department HIV / AIDS programs. According to one participant, " [capacity building is] a broader role that needs to cross all health issues...[however] again, HIV takes a leadership role where the rest of public health has failed." Another participant expressed more comfort with HIV / AIDS program provision of TA / CBA to CBOs, "...I see it as our role. I think that in order for our grantees to be successful...we have to do everything we can." Findings from the focus group did, however, highlight that health departments are committed to providing technical support, more broadly, to CBOs and perceive that health departments have an important and essential role to play in this regard.

Two survey questions asked respondents to identify the ways in which health departments and national / regional minority organizations (NRMOs) are uniquely qualified to address the technical assistance needs of minority-operated CBOs.

Survey respondents identified the following as areas in which health departments are uniquely qualified to provide assistance and support to minority-operated CBOs: Using epidemiological data; needs assessment; designing effective interventions; program planning; development of objectives; program evaluation; quality assurance; interagency coordination; networking; and intervention implementation.

The most important dimension through which health departments are uniquely qualified to provide technical support to CBOs, however, is related to the breadth of perspective that being a jurisdiction-wide agency with statutory responsibility for

ensuring the public's health affords. Responses highlighted that health department HIV / AIDS programs and their staff have extensive experience with and a long-term commitment to HIV / AIDS. Health departments posses a broad view of local resources, the political environment and interagency relationships. Many health department respondents cited long-term relationships with a variety of community-based providers. These factors place health departments in a unique position to rapidly and effectively assess and address the technical assistance needs of local providers of HIV / AIDS services. Health departments are well positioned to provide technical support on an ongoing and relatively intense basis and can serve as "brokers" of peer to peer assistance between CBOs.

Findings from the survey questionnaire suggest a wide variety of resources, skills and expertise are available through health departments. The "in-house" capacity of health departments to provide technical assistance appears to vary widely, with some respondents indicating a cadre of staff with broad expertise and experience to address a wide range of technical assistance needs, many having been formerly affiliated with community-based providers. Some respondents report working with other divisions within the health department (e.g. office of minority heath) to provide technical assistance to local grantees. Still, others provide access to technical assistance through contractual arrangements with universities or other providers.

Findings suggest that health departments view national / regional minority organizations (NRMOs) as best suited to providing technical support in those areas which are not traditionally within the purview of public health - those which are related to organizational development and management of non-profit agencies. Specific topic areas mentioned by survey respondents included: board development / recruitment, fund raising, volunteer recruitment, program planning and management, culturally competent interventions, and "tech transfer" of interventions.

Survey findings suggest that the effectiveness of NRMOs in providing technical support is limited by a number of factors. Of particular concern to respondents is that NRMOs are not in a position to provide ongoing intense individualized technical support to CBOs. Findings generally suggested that NRMOs are best able to provide generalized technical assistance on issues related to management of non-profit agencies and on culturally specific intervention strategies.

Building Health Department Capacity to Address Technical Assistance Needs

"With current staff or resources, we may not have what those CBOs are looking for or will accept from us…" – AIDS director in focus group

Respondents were asked to indicate the types of resources needed to facilitate fully addressing the unique technical assistance needs of minority-operated CBOs. Of the 49

respondents who completed this question, 37 indicated that additional funding and/or expanded staff were essential to addressing technical assistance needs.

Respondents also expressed a desire for current staff to enhance knowledge and technical skills and abilities around issues identified as key technical assistance needs for minority-operated CBOs. A number of respondents indicated a need for staff to enhance their knowledge and skills on topics related to organizational development and program administration (e.g. strategic planning, board development, fiscal management).

LIMITATIONS OF ASSESSMENT FINDINGS

Several limitations apply to the analysis of these data. Where multiple responses to survey items were included, these likely were interpreted differently by respondents. Items related to the technical assistance and training opportunities currently offered by health departments should be considered broad topical areas. Additional information is required to determine the format, content and frequency with which such opportunities are offered.

Open-ended questions were interpreted by respondents on the basis of their experience and expertise. Lower prevalence jurisdictions, particularly those with relatively small racial/ethnic minority populations, are less likely to have had opportunities to interact with NRMOs than are higher prevalence jurisdictions. Finally, the survey sample was limited to health department respondents only. It will be important to examine both CBO perceptions of priority technical needs as well as the capacity of health departments and NRMOs to address these needs.

CONCLUSIONS

Findings suggest that health departments are appropriate and credible providers of technical support to minority-operated CBOs. Health departments, however, are limited in their ability to provide appropriate and effective technical support due to inadequate resources. Additional funding to support development and implementation of technical assistance/capacity building activities must be made available to health departments.

NRMOs provide an important and critical source of expertise for minority-operated CBOs, particularly in the areas of organizational development and management. However, to be most effective in providing useful and appropriately targeted assistance and support, it is essential that NRMOs partner with health departments.

TA/CBA CASE STUDIES

Findings from the first phase of the STATUS project pointed to both a great deal of variability in health departments' responses to TA/CBA for minority community based organizations. At the same time, findings suggest significant activity, interest and development of TA/CBA programs within health departments. The following case studies represent just some of the many innovative health department approaches to developing capacity and providing technical assistance to minority communities. NASTAD has profiled other approaches in separate publications.

New Jersey: Organizing for Community Development

A 1994 survey of members of the HIV Prevention Community Planning Group (CPG) in New Jersey revealed that one of the priority needs in the state was capacity building for community-based organizations. Although a small state geographically, New Jersey has a large population, much of it concentrated in largely impoverished, mid-sized cities such as Newark, Jersey City, Camden, and Trenton that are very much part of the Northeastern coastal epicenter of the U.S. AIDS epidemic. In addition, some of the first cases of HIV acquisition associated with injecting drug use and mother-to-child transmission were identified in New Jersey, leading to an epidemic largely concentrated among ethnic and racial minorities. Thus, it is among community-based organizations serving these communities that capacity building is most urgently needed.

According to New Jersey HIV Prevention Director Steve Saunders, it was in response to these epidemiological realities that the Division of AIDS Prevention and Control of the New Jersey Department of Health and Senior Services created Organizing for Community Development (OCD), a distinct entity providing technical assistance and capacity building. Headquartered in the Department of Health Education at Rutgers University, OCD also represents an innovative partnership between the State Department of Health and the State University of New Jersey.

OCD's mission is straightforward: "to help reduce the incidence of HIV infection in New Jersey by building the capacity and skills of community-based organizations (CBOs), HIV/AIDS service organizations, and local health departments." In pursuit of this mission, OCD seeks to be "a catalyst for building strong, healthy communities through opportunity, leadership development, collaboration and advocacy." In the first five years after its founding in 1995, OCD provided training to over 750 people in grassroots organizations as well as technical assistance to more than 50 New Jersey-based agencies.

Among OCD's services are a website (http://healthnet.rutgers.edu/ocd) with up-to-date information on funding and other issues, seminars organized whenever major new

requests for proposals (RFPs) are issued, and one-on-one technical assistance regarding organizational infrastructure, community mobilization and other topics. It also offers seminars on such topics of relevance to non-profit organizations as human resource supervision, employer-employee communications, fiscal responsibility, using the World Wide Web and the Internet for technology transfer, developing evaluation plans, and teambuilding in the workplace. Three of OCD's other core programs are profiled below: the Grassroots School of Grantwriting (GSG), the Empowerment Training for People Living with HIV / AIDS, and Behavior Theory Change Trainings.

Grassroots School of Grantwriting

According to OCD Director Nataly Evans, the GSG has perhaps been OCD's most successful program. Since its inception in 1995, the GSG has expanded from being a series of three daylong trainings to eight daylong trainings, now covering such topics as how to: conduct and write a needs assessment; understand statistics and behavior change theory and incorporate them into grants; develop a program narrative; translate community needs into programs; and develop budgets and evaluation programs. Beyond these specific topics, however, Evans stresses that the GSG tackles larger issues relating to program management, communications, and interagency collaboration. GSG trainings also incorporate such larger dimensions as the need for diversity, the impact of racism, the influence of politics and government systems, and the need to understand target populations.

GSG's training series are held biannually and each includes approximately 25 participants who complete a pre-program survey and personality evaluation. Based on these surveys, the participants are divided up into four different mock agencies, one university-based, one a women's project, one faith-based, and one AIDS service organization. Maintaining these "identities" throughout all eight sessions, the agencies learn how both to collaborate and to compete in the grantwriting process. To ensure the full involvement of all participants, registration requires the approval of the agency's executive director for participation in all eight sessions. Those who complete all eight sessions receive $40 of their $200 registration fee back and also receive a certificate of completion, while those who miss even one session do not. (There is also an intensive three-day version of the GSG.) Target audiences include executive directors, health educators, program coordinators and directors, social workers, and program developers from such organizations as hospitals, foundations, universities, small CBOs, AIDS-service organizations, and faith-based agencies. Reflecting the epidemic in New Jersey, many of the participants are African American or Latino, and / or represent minority CBOs.

Although Evans said there is a standardized manual, each GSG is tailored to the specific needs of its participants. She stresses that the outcome measure is not simply the completion of the eight sessions, but rather the participants' subsequent success in

bringing services to their clientele by applying for and being funded for more grants than they had before the GSG. To this end, participants are followed up at six weeks and then at six, nine, twelve, and eighteen months.

As of early 2000, the 200 individuals trained by GSG have brought in more than $50 million to New Jersey-based programs that would likely not otherwise have been funded. Among these funds have been $800,000 for the development of housing for people with HIV/AIDS in Essex and Monmouth Counties, $250,000 a year to the Interfaith Community in Newark, over half a million for HIV prevention in Hudson County, and a million dollars for HIV prevention and drug treatment in Essex County. In addition, GSG participants have greatly increased the number of grants for which they apply, making it likely that funding levels will increase over time.

Empowerment for People Living with HIV/AIDS

In association with the Union County HIV Affected Caucus and the Union County HIV Consortium, OCD in late 1998 issued a Manual on Issues and Resources for Community Empowerment. The manual identifies that its "challenge is to train HIV-positive individuals and community representatives to be effective decision makers, rather than members appointed to planning boards only to satisfy legislative requirements…This manual provides members of planning bodies with that sense of belonging and self-worth that is so necessary in the struggle to meet the challenges of HIV disease."

The training guide comprises three modules, respectively on self-empowerment, education, and "the consumer as decision-maker," along with information on "conflict as a sign of group health." By way of example, Module 1 covers topics from the perspective of a person living with HIV/AIDS such as self-analysis, denial and disclosure, self-assessment of the future, intervention choices, and managing the disease. The module "promotes self-actualization and prepares individuals to engage in his/her own management of HIV disease."

"Theory to Practice": Behavior Theory Change Trainings

After the state of New Jersey began requiring that its grantees use the Partners and Prevention curriculum in their prevention work, OCD conducted trainings on how to understand and apply the behavioral change theory that is the framework of the curriculum. Entitled "Theory to Practice," this series teaches participants how to integrate states of change theory into their programs. Taught with the participation of the curriculum's authors from the Center for AIDS Intervention Research (CAIR) at the Medical College of Wisconsin, the two-day program identified the crucial role of different prevention team members in working with clients at different stages of self-control of sexual and drug-use risk behaviors.

According to OCD Program Development Specialist Deborah Lewis, the training participants included outreach workers, health educators, case managers, and program coordinators from agencies throughout the state serving women, youth, and men who have sex with men. Focusing on two stages at a time (such as the first two, the "precontemplative" and the "contemplative") and making extensive use of case studies, the trainings enabled providers to apply the Partners and Prevention curriculum in a thoughtful and informed manner. After being piloted by OCD, the trainings are now directly administered by the state's Division of AIDS Prevention.

Key Future Challenges for Capacity Building in New Jersey

Both Evans and Lewis emphasized that, in the experience of OCD, capacity building is a long-term process requiring a commitment to close collaboration with target agencies and communities. Although in existence for five years, it was only in 2000, for instance, that the Grassroots School of Grantwriting rosters began routinely filling up well in advance of their first session. Although the activities of OCD have become well known among the state's HIV / AIDS service provider community, it took a while for advertising, outreach, and word of mouth to establish OCD as a credible source of information and services and to develop relationships with key individual providers. This process was assisted by the fact that while OCD was established by the State, organizations in New Jersey are not directly funded by or through OCD, making them more willing to identify their capacity-building needs to OCD without the need to reveal organizational shortcomings to a funder.

Evans noted that the State has been quite responsive to requests for supplemental funding, enabling the program in move in new directions. A primary managerial challenge, she indicated, has been recruiting program staff who already have or can develop credibility and trust in the community, have the appropriate professional skills, are willing to work long hours for modest pay, and are drawn from the same social groups as the people with whom they are working. In addition, program staff must have detailed knowledge and understanding of specific populations in particular locations, given that needs vary widely not only from state to state but even within small states and individual communities. For this reason, Evans generally supports the state and local level, rather than national-level provision of capacity building services.

Now that OCD has become established, Evans has begun to turn her attention to those sectors of the community that have not yet been reached by OCD services. These organizations, many of which are based in African-American communities with a history of poor treatment by government and society, may well be those who could most benefit from OCD's services. Thus, a future endeavor will be to not only respond to organizations who approach OCD, but also to proactively follow-up with agencies who do not respond to OCD mailings and surveys in order to determine their needs and empower them to engage a system they may have avoided in the past.

Technical Assistance and Capacity Development: Michigan's Approach

Beginning in 2000, Michigan established a formal technical assistance and capacity development project for local HIV / AIDS service providers. There are three components to the project: (1) individualized technical assistance to grantees; (2) technical assistance workshops; and (3) a capacity development (CD) series. The project is intended to provide a broad range of expertise, experience and opportunities to local HIV / AIDS service providers. The project, which was a full year in development, is managed by the HIV / AIDS Prevention and Intervention Section (HAPIS) of the Division of HIV / AIDS and STD in the Michigan Department of Community Health. The format of the project and the content of the TA and CD workshops were determined in close consultation with an advisory group comprised of representatives of community planning groups and local service providers. An assessment of technical assistance needs of local prevention and care service providers was also conducted.

Individualized Technical Assistance

Each HIV Prevention Services Grantee of HAPIS / DHAS is assigned a "contract monitor" from among staff. Staff with these responsibilities possess a broad range of experiences and expertise in all areas of program operation and delivery of services. Through regular contact and observation, contract monitors are able to assist grantees in identifying and meeting technical assistance needs. Identified needs may be met through existing staff resources, through peers or through "expert consultation." HAPIS / DHAS monitors assist grantees in securing appropriate assistance.

Technical Assistance Workshops

A series of six one-day workshops is held annually. Topics of the workshops include: Program Development, Translating Theory into Practice, Needs Assessment and Selection of Interventions and Services, Developing Realistic Program Plans, Outcome Based Evaluation, Program Budget Development and Management, Grant Writing and Review, Staff and Volunteer Recruitment, Agency Management and Support, and Interagency Collaboration and Coordination.

Workshops are open to all interested parties and are offered at no cost. The TA workshop series is marketed to current HIV prevention service grantees, Ryan White Titles I and II grantees, local public health agencies, community-based organizations funded directly by CDC and other local prevention and care service providers. Participants may chose one or several of the workshops to attend. The workshops are designed to be "stand alone," are relatively didactic and participants are provided with a variety of materials related to the topics covered. Expertise in the various topics is

drawn from national as well as local resources.

Capacity Development Series

The Capacity Development (CD) Series is comprised of a series of six two-day sessions attended by a cohort of 18-20 professional staff. The overall goal of the CD series is to enhance the capacity of local service providers to develop, implement and evaluate effective HIV prevention and care programs. The topics addressed in the CD series parallel those offered in the TA workshops. Expertise in the various topics is drawn from national as well as local resources. The CD series is, however, much more intensive in nature in that it includes a variety of in-class exercises as well as graded "homework" assignments which allow immediate application of lessons learned to the work of the agency. Feedback is provided by series faculty and HAPIS/DHAS staff. Each session of the Series is designed to "link" with the preceding and subsequent session.

The CD Series is open only to community-based service providers of HIV/AIDS services. Priority for participation is given to those agencies that receive funding from HAPIS/DHAS for HIV prevention or which receive Ryan White Title I or II funding. Preference is also given to agencies which have been providing HIV/AIDS services for fewer than three years. In selecting participants, consideration is given to ensuring that at least one provider within each of the state's eight planning regions is represented in the cohort. Participants are also selected with an eye towards balancing the representation of prevention and care service providers. The CD series is offered free of charge and participants are provided with travel support to facilitate their participation.

Because of the time and resource commitment associated with participation in the CD series, the participating individual must be someone with a long-term commitment to the represented agency, be in a position within the agency to best apply the knowledge and experience gained through participation in the CD series to agency and program development/management, and be someone who can make a commitment to full participation in the series, including completion of homework assignments.

The TA workshops and CD Series were first implemented in 2000. Eighteen of twenty participants completed to full CD Series. Overall, 56 individuals representing 40 agencies participated in at least one of the TA workshops. The majority attended two or more. Formal evaluation of the TA workshops and CD Series is underway, with results expected to be available by January 2001. Provisional analysis suggests that the TA workshops and CD Series were well received and that participants obtained great benefit from their participation.

Rhode Island: Project REACH

Project REACH, a nationally known TA/CBA service provider, was launched in 1994 as a result of discussion within the Rhode Island community planning group (CPG). According to Rhode Island AIDS Director Paul Loberti, Project REACH has, from the outset, involved not only organizations with an HIV-specific focus, such as AIDS Project Rhode Island, but also non-HIV-specific agencies whose clientele are at high risk for HIV infection. This outreach began with providers in the field of domestic violence and is being expanded to include those focusing on mental health and substance abuse. Loberti said that many such organizations were not necessarily incorporating HIV prevention messages into their work but have begun to due to the work of the Project.

Since its inception, Project REACH (whose acronym refers to Relating, Exchanging, And developing Capacity for HIV prevention programs) has been coordinated with the CPG, which continues to identify needs and gaps in services. In turn, Project REACH has conducted ongoing needs assessments to specify what services are needed and where they are needed. This process led to, among other things, the development of the "Inner Circle," a roundtable composed of youth who plan and direct prevention services for their peers. Project REACH's broad focus has also led to unanticipated collaborations, including one between a Catholic Latino service organization and a gay youth organization. These and other organizations, which might previously have had incompatible missions or viewed themselves as competitors, have been enabled to see themselves as strategic allies by forging organizational and individual linkages.

The Rhode Island Department of Health (RIDOH) has subcontracted much of the work on Project REACH to a vendor, Initiatives for Human Development (IHD), the mission of which is "to foster healthy lifestyles in all populations through training and prevention programming specific to the needs and settings of individuals and communities." It takes as a motto the concept that "give people fish and they eat today, teach them to fish and they eat forever," leading them to emphasize longer-term capacity building over shorter-term technical assistance, with an emphasis on cultivating relationships and resources to help key people within organizations and communities. IHD is headed by Executive Director Sandra Puerini Del Sesto, while Project REACH is managed by Coordinator Don Mays. The subdivision of duty between the state and IHD has enabled agencies to feel more comfortable identifying the areas in which they need improvement without concern that they are revealing "weaknesses" to a major funder.

Philosophically, Project REACH emphasizes the bi-directional nature of collaborations, in which both agencies and communities – as well as the individuals among them – exchange information, skills, needs, and resources. From the Project REACH perspective, sustainable capacity building must be carefully tailored to the specific needs of an agency and/or a community. In addition to providing ongoing networking

and technical support, the project provides experiential retreat trainings and topical workshops using theory-based "best practice" strategies to educate and inform the key people within organizations. Among the workshops' anticipated outcomes are enhancement of leadership skills, development of collaborative strategies, improvement of advocacy skills and communication, increasing cultural competency and sensitivity, identifying alternative funding sources and improving grantwriting skills, and conducting evaluation and forward planning. Project REACH also coordinates six-month to one-year internships at agencies such as the domestic violence agency Sojourner House, the Visiting Nurses Association of Rhode Island, Talbot Women's Day Treatment Center, and the YWCA.

Evaluation Methods

Project REACH conducted an evaluation training retreat at Bryant College in July, 2000. The training was designed to provide participants with a clear understanding of the Logic Model of evaluation as a way of enhancing the HIV prevention work. Specific outcomes of the training, which is built around presentations and work group activities, were for participants to have a working definition of program evaluation, understand its importance to programming, evaluate a current program, apply the "Logic Model" of evaluation to their program, and match programs with appropriate evaluation methods. Thus, participants gain an understanding of evaluation as not simply a chore necessary to meet reporting requirements, but as a tool for setting realistic, theory-based program goals and making ongoing adjustments in order to achieve those goals.

Leadership Development

Another emphasis of Project REACH, according to Mays, is identifying individuals who are leaders within their communities and/or agencies and helping them to further develop their leadership capacities. Their approach to leadership, Mays says, is not a "top-down" perspective in which authority flows through an organizational chart, but rather an "inside-out" perspective in which individuals find and express their inner capabilities. To maximize the possibility that new leadership skills can be successfully applied within the CBO context, participating agencies are asked to send not just one individual but two or three, so that they can continue to work together to implement change. Some program alumni return to serve on a planning committee to keep Project REACH closely connected to its client base.

A Broadening Focus

According to Loberti, Project REACH has been an integral component of the attempt to grapple with an HIV epidemic which is surprisingly large considering the small size and population of his state. While focused largely on the capital city of Providence, the program also serves populations such as Native Americans along the Massachusetts

border and residents of more isolated islands in the southern part of the state. Applying its own philosophy of collaboration, Project REACH has proposed a "Project REACH National Training Center for HIV Prevention" that would help to extend this successful model beyond the borders of Rhode Island. Even as it looks outward, however, Project REACH has new goals for itself within Rhode Island, including establishing stronger connections with agencies serving the state's growing ethnic Hmong (Cambodian) population and supporting the HIV work of Native American agencies that are new to the issue.

The Urban League of Rhode Island - A Project REACH Client Case Study

Agencies that are eligible for participation in Project REACH are those serving ethnic / racial minorities and / or special populations at specific risk. Among the many organizations that have benefited from Project REACH trainings, one of the most prominent is the Urban League of Rhode Island, a branch of the national Urban League organization. Indeed, according to HIV / AIDS Prevention Services Coordinator Toni Roderick, her agency might not even be offering sustained HIV / AIDS prevention services had it not been for the introduction to the field supplied by the work of Project REACH. Working previously in maternal and child health, Roderick first attended a single Project REACH training, an experience which heightened her awareness of the need for intervention among the highly vulnerable populations serviced by the Urban League, which has a history of over sixty years of community service in the state.

Roderick indicated that she had little difficulty in persuading her organization about the need to work on HIV-related issues, but that the agency had struggled in doing so previously because of a lack of capacity building and technical assistance. Today, the program consists of a series of six, two-hour life-skills workshops held weekly or biweekly. Sequentially, the workshops cover relationships and communication, HIV risk and knowledge, "trigger management" and problem solving, condom skills, substance abuse and prevention, and maintenance and relapse prevention. Her program also now offers case management services, group counseling, education, and employment opportunities and referrals, with services provided free of charge in both English and Spanish.

In addition to the substantive education in the specifics of HIV prevention, Roderick credits Project REACH workshops and one-on-one capacity building with enabling her to launch a program which – unlike previous Urban League efforts – has been sustained and expanded over time, with the program staff expanding from one person to seven in just two years. After beginning with women who had been released from correctional facilities, the program expanded to cover a broad range of populations, particularly among communities of color.

APPENDIX A
Methodology of the STATUS Project

The STATUS Project employed a variety of research methodologies and drew on a number of distinct data sources. Among these were a comprehensive review of the relevant scholarly literature (see appendix B below); focused discussion groups with AIDS directors and/or members of their staffs; an assessment distributed to all members of NASTAD; and an extensive extraction process of materials prepared by state, territorial, and local health departments. This study sought to provide a portrait of current programming, as well as the perceptions of AIDS directors, in the areas of TA/CB to minority CBOs, targeted testing efforts, and referral systems.

Literature Review

The literature reviews for the sections on technical assistance/capacity building assistance were conducted by The Policy Resource Group under the direction of Beth Meyerson, M.Div. Based on research questions and key words/phrases, electronic searches of peer-reviewed journals were conducted using OVID, Congressional and Academic Universe databases. The results were synthesized into comprehensive literature reviews.

Development of the Assessment

The assessment was designed based directly on the fundamental research questions posed in NASTAD's original application to the CDC for funding for the STATUS Project. The content and wording of questions were derived primarily from the literature review and from a focused discussion group held in December 1999. This focused discussion group, which included six AIDS directors, employed a standard focused discussion group process, including the use of a moderator and an observer along with an open-ended outline with probes touching upon all the major components of the STATUS Project.

In a number of places, the assessment includes questions with straightforward response categories derived from the literature review. In other places, the assessment employs open-ended questions alongside parallel closed-ended quantitative questions. The assessment was designed taking into consideration face validity, content validity and acceptability of length so as to avoid overburdening respondents. Because NASTAD assessments seek to achieve a response from all 65 directly funded jurisdictions, issues of sampling and generalizability did not come into play. A first draft of the assessment was reviewed by select state and local AIDS directors for question content and clarity and was revised based upon their feedback as well as that from CDC.

Data Collection and Analysis

The final version of the assessment was distributed to NASTAD members and the local health department jurisdictions directly funded by CDC in early February 2000 with a request that the assessment be completed and returned to NASTAD. Follow-up efforts eventually succeeded in garnering a response rate of over 90 percent of the states, along with a number of directly funded cities and territories. The data derived from the assessment were compiled by NASTAD staff and analyzed by Liisa Randall.

Case Studies

The Model Programs and Best Practices highlighted in the case studies were identified through a variety of sources, including: 1) recommendations by AIDS directors provided on the assessment; 2) extractions conducted from jurisdictional applications to CDC; and 3) objective criteria (e.g., replicability, practicability, demonstrated results) identified by AIDS directors through the assessment and focused group discussions. Case studies were compiled through key informant interviews, site visits with direct observation, and materials review. Specific areas emphasized within case studies were chosen in order to highlight major findings from the assessment.

APPENDIX B
Technical Assistance and Capacity Building: A Review of the Literature

Research Questions

- What technical assistance and capacity building services do health departments provide to minority community based organizations (CBOs)?
- What training, technical assistance and capacity issues do minority CBOs face?
- What are the unmet needs of health departments and (minority) CBOs?
- What programs are "model programs" that could be implemented elsewhere?

Method

Peer reviewed journals were searched using OVID, Congressional and Academic Universe databases using the following terms and phrases:

- Technical Assistance
- Local Health Departments
- Capacity Building
- Minority Organizations / Programs
- Local Health Technical Assistance
- Capacity Building for Minority Organizations
- Technical Assistance to Minority Based Organizations
- Model Programs
- Community Based Organizations

A variety of search phrases were used with the above terms such as "technical assistance to minority organizations," "capacity building for minority organizations," "model programs for technical assistance," etc.

Results

The bulk of the literature on technical assistance referred to the realm of international technical assistance efforts. There is a rich history of such activity that might provide some basis for future policy conceptualizations around technical assistance. International literature did echo common challenges faced by nongovernmental organizations in the United States such as dependence upon governmental funding, tensions between routinized bureaucratic structure / formalization and social change strategy / charisma (OECD, 1969, Minkoff, 1993).

Though a consensus definition of technical assistance was not found in the international literature, "tasks" of technical assistance were identified and reflected activities occurring in the United States in the field of HIV. Such tasks include general training, technical training, management, research and advisory work (OECD, 1969). These tasks have not changed much in the international literature since 1969.

Notions of capacity building from international literature in HIV prevention often overlapped with those of technical assistance, and there was a lack of consensus on definition. Initial conceptions of capacity building involved the provision of funding and equipment, increasing financial accountability and strengthening specific skills. Over time, technical assistance and capacity building activities expanded to include consultation regarding management of organizational growth and strategic planning (Kotellos, 1998). According to Kotellos and colleagues, capacity-building programs must provide strategies "focused at the institutional, organizational and individual levels" (ibid). Kotellos offers a model for evaluating capacity building efforts, measuring for their effectiveness in terms of development of human resources (individual level), organizational systems, funding diversification and structure development (organizational level), and interorganizational / multi-sector linkages (institutional level). Table 1 on p. S110 of the Kotellos article describes the following capacity building strategies: technical skill building, management skill building, management systems development, resource diversification, network building, organizational cross-fertilization and multi-sectoral collaboration. Organizational sustainability was defined as a key outcome of capacity building efforts (ibid; Gentry, 1999; Minkoff, 1993). Table 3 of the Kotellos article (p. S112) identifies indicators for capacity building evaluation. Though the focus of her article was international efforts, the applicability to domestic efforts is clear.

Though mainly described in terms of discrete tasks, capacity building was understood to be a process, or to be delivered in the context of a relationship (Gentry, 1999, Kotellos, 1998). According to Kotellos: "Building capacity is a process in which training and technical assistance play only a part. Developing and internalizing skills, knowledge, and a clear understanding of complex concepts or procedures, all fundamental elements of capacity, demands nurturing and continual attention" (p. S115).

A key issue is the conceptualization of capacity building and technical assistance from the perspectives of different organizations. Kotellos and colleagues noted the importance of building consensus around capacity building efforts, particularly given the diversity of needs and issues facing organizations (1998, see also Gentry, 1999). Consensus building can be a challenge, given the multiple views and agendas. For example, from the perspective of local health departments, capacity building and technical assistance refer to activities either provided to the local health department by the state health department or national organizations such as the National Association of County and City Health Officials (NACCHO), or services provided internally to local health department employees. Technical assistance to community based organizations, or minority organizations for that matter, was not found to be included as a core public health activity (Turnock, 1995; Richards, 1995; Scutchfied, 1997; Suen, 1995).

The phrase 'capacity building' in the public health literature connoted local health department (LHD) capacity to deliver core public health services. The role of capacity

builder referred to "improve[ing] LHD practice effectiveness" (Turnock, 1995). Technical assistance to local health departments was defined as assistance to LHDs "to define terms and (local health) practice concepts" (ibid) or required continuing education or professional training (Public Health Foundation, 1995).

As the research question involves health department provision of technical assistance (TA) or capacity building assistance (CBA) to minority CBOs, the capacity of health departments to deliver the TA / CBA becomes important. The framing of technical assistance and capacity building from the perspective of the public health literature indicates CBOs are really not on the radar screen of local health departments.

According to a 1996 survey of local health departments, lack of resources was cited by 82% of respondents as a barrier to the implementation of core public health services. Though respondents reported an increase in activities associated with community relations and citizen participation from 1989 to 1996 (28% increase), and an increase in relationships with voluntary health organizations (29% increase); such activities did not necessarily involve the strengthening of CBO capacity to deliver local public health services such as HIV prevention or HIV service provision. Mention was made regarding local health departments' "effort to use persuasion of voluntary health agencies to assist in the assurance function" (emphasis mine, Scutchfield, 1997).

Stress in relations between state and local health departments emerged prominently in the literature and suggests a challenging issue for the research project. If the goal is to strengthen health department provision of technical assistance and capacity building services to minority CBOs, there may need to be an assessment of the nature of the state and local health department relationships. In a 1992-93 survey, local health departments cited state health department intrusion and the lack of resources as barriers in the provision of core public health services (Turnock, 1995). Scutchfield, et. al., noted that the levels of support by state health agencies to local health agencies, and the role confusion between state and local health departments impacted the delivery of core public health services by local health departments (1997).

Technical Assistance and Capacity Building Services for Minority Organizations

As in the international literature, there is a lack of clear definition for the term "technical assistance" in the domestic literature. Activities of technical assistance involved building organizational capacity to respond to HIV at both governmental and community based organizational levels through activities such as program development, organizational "enhancement" and "improving the infrastructure of organizations" to provide culturally competent services to the HIV community. Specific services included HIV / STD prevention program information, training in human resource management, volunteer recruitment / retention, fiscal management, budget development and writing. Other activities involved the teaching of skills,

provision of referrals, networking and building relationships among various community based organizations (Gentry, 1999).

In a recent study to assess the effectiveness of technical assistance provided by national and regional minority organizations (NRMOs), a reported 56% of T/TA recipients were community based organizations and 11% were health departments. The remaining types of respondents included colleges, planning groups and other organizations; and were not highly represented as recipients of T/TA by NRMOs (Gentry, 1999).

An important issue emerging in the literature was the cultural competency not only of HIV prevention provider among minority populations, but also the cultural competence of the technical assistance provider. Cultural competency was understood to be an organizational capacity and referred to sensitivity to the various cultural issues, languages and customs, as well as representing the cultures when delivering technical assistance; and an ability to draw upon these in the construction of community interventions (Chng, 1998; Gentry, 1999). Cultural competency is the grounding for credibility.

The goal of the CDC National Minority Organization HIV Prevention Program, established in 1988, was to "strengthen HIV/AIDS prevention efforts among racial and ethnic minority communities by working through national organizations that had credibility and expertise with these communities" (Gentry, 1999). These national organizations would strengthen both the organizational capacity of local minority AIDS Service organizations and the capacity of health departments to work with minority communities and organizations. Gentry, et. al., studied the effectiveness of these organizations. Findings will be discussed throughout this review as appropriate.

With regard to minority organizations generally, the more they reflect moderate objectives targeted to nonpolitical arenas, the more secure the organizations are (Minkoff, 1993). Such a reality reflected the inherent tension between organizational conformity (or routinization) and social change mission (or charisma); or how activism is "subject to the inertial forces that tend to plague formal organizations" (ibid, Streeten, 1997). Streeten, citing Judith Tendler notes: "NGOs often derive their identity by defining themselves in contrast and opposition to government…In spite of this rhetoric, the relations between NGOs and government are often complex, rich and intricate" (1997:206, citing Tendler).

A study assessing organizational characteristics contributing to the viability of national African-American, Hispanic, Asian-American and women's organizations from 1955-1985 (Minkoff, 1993), indicated that ability to acquire resources and to "convince powerful actors" such as funders and authorities, are crucial to organizational survival. Such activities require organizational capacity and may conflict with the culture of the organization at different stages, even narrowing the possibilities of organizational

structures and tactics. Herein lay the challenges to the provision of technical assistance and capacity building to minority organizations by health departments (read: government sponsors). Organizations wish to increase resources, and as such must establish organizational "marks" of legitimacy. Emergent structures, then, respond to the externally derived agenda for the nonprofit sector and may be in conflict with volunteer, socially motivated members of community based organizations, often characterized as "bottom up" or "grass roots" organizations (Streeten, 1997). Where there is cultural discrepancy between the organizations and the government, the tension may be the greatest. For example, "authorities are likely to prefer to deal with organizations that state less comprehensive versions of (social) change" (Minkoff, 1993).

In a recent study to assess the training and technical assistance (T/TA) provided by national and regional minority organizations (NRMOs), researchers found seven primary approaches to building organizational capacity for HIV/STD prevention efforts. They include: Training/Technical Assistance (T/TA) partnerships lasting one year or longer, expedited T/TA, provision of funding, training for trainers, use of existing network/constituents, culturally specific approaches incorporating customs, beliefs and shared experiences and epidemiologically driven T/TA. The primary sets of variables included Critical Success Factors (governance and management) and Performance Indicators (extent of change in HIV/STD prevention program capacity attributable to the technical assistance) (Gentry, 1999).

NRMOs marketed their training and technical assistance services through publications, site visits, the coordination of community meetings and "word of mouth referrals" which included referrals by local and state departments of health and the CDC. NRMOs reported assessing the need for capacity building by reviewing the needs of a particular target community or the needs of a target organization as articulated to them through a NRMO technical assistance application process. It was notable that 32% of minority organizations reported receiving technical assistance from NRMOs also received "mini grants" or other forms of funding (Gentry, 1999).

In a 1997 national survey among Asian and Pacific Islander organizations (APIs), technical assistance most frequently requested included program development, staff development and program evaluation. When rating the importance of technical assistance needs, APIs rated fund raising (3.96/4.0), strategic planning (3.84/4.0) and needs assessment (3.76/4.0). Despite the high rating for fund raising and the recognized dependence of nonprofit organizations on resources, only 18% of APIs reported receiving technical assistance in fundraising in the past year (1996-1997). Given APIs low rating for HIV prevention community planning processes, researchers recommended technical assistance in fund raising, program evaluation and participation in the HIV prevention community planning process (Chng, 1998).

Technical assistance to APIs was provided mostly by "local training centers" (52%), other local AIDS Service Organizations (46%), state health departments (43%) and national/regional minority organizations (NMAC – 25%, API Wellness Center – 18% and API American Health Forum –37%). The most common means of receiving technical assistance included training attendance (77%), training workshops and conferences (64%) and "newsletters and publications" (49%) (Chng, 1998: p.56, table 6).

In a recent study evaluating the effectiveness of NRMO T/TA, recipients of technical assistance and training did not overwhelmingly articulate how T/TA strengthened their HIV prevention efforts. For example, the most frequent statement (13%, n=210) was that T/TA increased awareness of HIV prevention. Only 10% indicated that T/TA improved planning or skills (respectively) (Gentry, 1999).

A significant number of APIs reported conducting only process evaluation to assess their HIV prevention programs (Chng, 1998). This reflected the practices of international HIV non-governmental organizations (Kotellos, 1998). Significant barriers to provision of HIV prevention programming reported by APIs include lack of government funds (84%), denial of risk among targeted populations (77%), homophobia (68%) and limited staff (74%), lack of private funding (74%) and lack of political representation and influence (63%) (Chng, 1998).

Given limited resources for non-governmental/community based organizations, there is much competition for resources. Such competition results in a reduced (or nonexistent) level of information sharing among minority organizations (Kotellos, 1998; Gentry, 1999).

A notable issue for discussions of health department provision of capacity building or technical assistance services is the fact that many minority organizations are heavily dependent on government sources of funding (Chng, 1998; Streeten, 1997). For example, 70% of APIs identified major dependence on federal funds (cf. 64% listing dependence on state funds) (Chng, 1998). Streeten cautions whether NGOs can maintain their independence as a third sector (nonprofit) and "resist becoming either agents of government or fee-charging private consultancy firms" (1997:194).

In addition to fund development and organizational consulting, minority HIV programs (and it appears CBOs generally) need assistance with research based interventions. For example, most APIs reported dissemination of HIV information as opposed to the implementation of behavioral interventions as their primary HIV prevention strategy (Chng, 1998). This finding was also reflected in two other studies among ASOs and other minority community based organizations (DiFranceisco, 1999; Gentry, 1999). In order to assure successful implementation of research based interventions for HIV prevention, ASOs will require significant staff training, technical assistance and consultation support (DiFranceisco, et. al., 1999). Authors indicated that

since ASOs are unlikely to consult the research literature when planning HIV interventions, technical assistance needs to involve the translation of research findings for adoption by ASO program planners (ibid).

At a minimum, a comprehensive approach to the provision of T/TA should include formal assessment of needs, written articulation of goals and objectives, plan for achieving objectives, written list of responsibilities and tasks, time line for achieving the tasks, and a way of measuring progress (Gentry, 1999).

The opportunity for NASTAD to make a contribution in the area of technical assistance and training to community based minority organizations is significant. Clarification of terms such as technical assistance and capacity building as well as an understanding of the perspective of state and local health departments regarding the receipt and provision of these services would further HIV prevention and treatment efforts significantly.

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